



GEORGIA COMPOSITE BOARD OF PROFESSIONAL COUNSELORS,
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APPLICATION FOR CLINICAL SOCIAL WORKER LICENSURE

SOCIAL WORK DIRECTED EXPERIENCE VERIFICATION FORM FORM B

INSTRUCTIONS: **NO FAXED FORMS ACCEPTED**

- Please print or type.
- **APPLICANT** – Complete Part I and forward this form to the agency or organization in which you completed your directed experience practicing Social Work.
- **AGENCY OR ORGANIZATION** - The Director must Complete Part II and return it to the Applicant for inclusion with the Application for licensure.

PART I – APPLICANT

NAME OF APPLICANT:

First

Middle

Last

Maiden

SOCIAL SECURITY NUMBER: _____

This information is authorized to be obtained and disclosed to state and federal agencies pursuant to O.C.G.A. 19-11-1 and O.C.G.A. 20-3-295, 42 U.S.C.A. 551 and 20 U.S.C.A. 1001. It may also be disclosed to the National Practitioner's Databank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB) or other licensing boards, or other regulatory agencies for license tracking purposes.

PART II – AGENCY OR ORGANIZATION

INSTRUCTIONS:

- "Direction" means the on-going administrative oversight of an employer or superior of a practitioner's work.
- For experience obtained **before 6/30/96**, one year of Directed Experience means a minimum of 800 hours in the practice of Social Work during a 12-month period within two (2) years of the application.
- For experience **after 7/1/96**, one year of Directed Experience means a minimum of 1000 hours in the practice of Social Work for no less than a year during the 36 months preceding the application.

CERTIFICATION

I CERTIFY THAT THE ABOVE-NAMED INDIVIDUAL PRACTICED SOCIAL WORK AT:

Name of Agency or Organization

Address: _____

Street

City

State

Zip Code

From : _____ To: _____ For _____ Hours Per Week.

Date

Signature of Director or Authorized Person

Name of Agency or Organization

Printed Name

Title/Position

Street Address

City State Zip Code

Telephone: ()

Fax: ()